STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003350	A. BUILDING: _____ B. WING _____	C 07/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT SETON SPECIALTY HOSPITAL, INDIANA	8050 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a licensure complaint. Survey Type: Licensure complaint IN00130480 Unsubstantiated, lack of sufficient evidence. Date of Survey: 07-01-13 Facility number: 003350 Surveyors: John Lee, R.N. Public Health Nurse Surveyor St Vincent Seton Specialty Hospital, Indianapolis is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-9, Radiologic services, Hospital Licensure Rules. QA: claughlin 07/12/13	S 000		